such as duration of follow-up and susceptibility to attrition bias.

We conclude that there is no current evidence that the patency rates are statistically significantly different for OPCAB and CABG. The pooled point estimate is unaffected by the flawed data analysis, so the risk of a vein graft occlusion using the OPCAB technique *may* be ≈25% higher. However, even if future data confirm that the risk is higher, the best answer to the question ''Dare we perform OPCAB… to merely improve [these] selected clinical and resource outcomes?''[4] is provided by analyses of outcomes that are more relevant to patients and less susceptible to attrition (survival free from major adverse cardiac-related events and health-related quality of life). There is no hint from a systematic review[6] or the BHACAS trials[2] that these outcomes are better after CABG than OPCAB, either in the short or long term.

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Notices of Correction

Re: Hypoxic reoxygenation during initial reperfusion attenuates cardiac dysfunction and limits ischemia–reperfusion injury after cardioplegic arrest in a porcine model. *J Thorac Cardiovasc Surg*. 2009;137:978-82.

In the above-noted article, the spelling of Dr Behjati's surname was incorrect. The corrected author list is printed below.

U. Abdel-Rahman, MD, P. Risteski, MD, K. Tizi, S. Kerscher, MD, PhD, S. Behjati, K. Zwicker, MD, M. Scholz, MD, PhD, U. Brandt, MD, PhD, and A. Moritz, MD, PhD

Re: Long-term results of percutaneous management of malperfusion in acute type B aortic dissection: Implications for thoracic aortic endovascular repair. *J Thorac Cardiovasc Surg*. 2009;138:300-8.

In the above-noted article, the spelling of Dr Meerkov's surname and his degree were incorrect. The corrected author list is printed below.

Himanshu J. Patel, MD, David M. Williams, MD, Meir Meerkov, MSE, Narasimham L. Dasika, MD, Gilbert R. Upchurch, Jr, MD, and G. Michael Deeb, MD